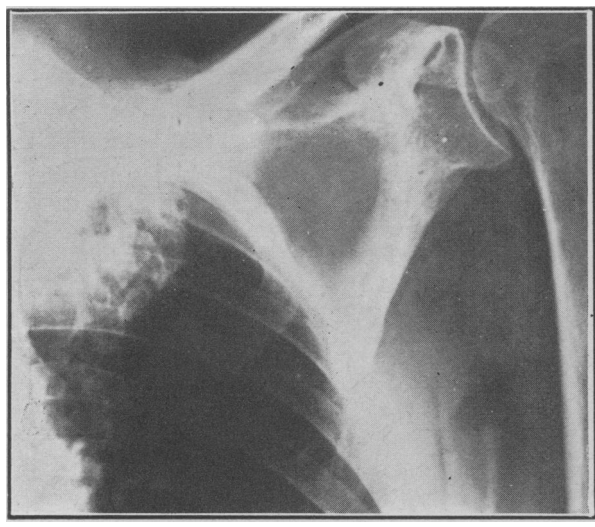

Fig. 1

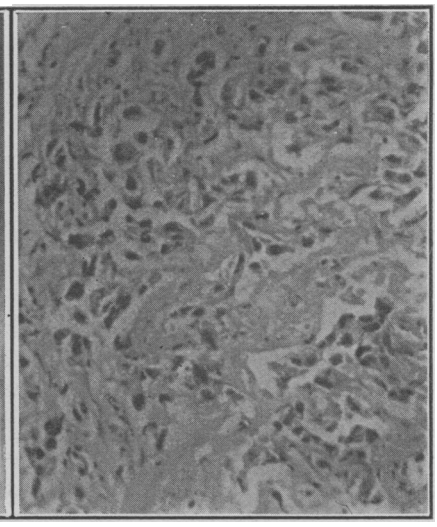

Fig. 2

to note that Hare[5] described a similar case in which he found at autopsy a hard nodular mass extending up to the origin of the brachial plexus. (2) Because of the fact that this apical shadow was noticed in September of 1934, being interpreted at that time as a pleural thickening. It is unfortunate that no photographic records were taken then. So far as I could judge, there was no noticeable increase in size of alteration in nature of this shadow. Feldman, Davidsohn and Danelius[2] suggest that dense pleural apical adhesions may precede development and growth of such a tumour and facilitate its expansion towards the thoracic wall and spinal column.

Pancoast was of the opinion that sulcus tumours originated from the epithelium, of one of the lower branchial clefts, but not from the lungs, pleura, ribs, or mediastinum. It is now believed that the entire symptomatology can be produced by any inflammatory or tumour mass, either primary or secondary arising in this location. Although apical bronchogenic carcinoma can therefore produce this clinical picture it is relatively unusual for it to do so. When such is the case there is striking absence of the usual symptoms of lung neoplasm, *viz.*, cough, mucoid expectoration, hæmoptysis, etc. It has, further, become increasingly apparent that invasion of rib and vertebræ is not as constant a finding as Pancoast considered it to be.

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Clinical and Laboratory Notes

STUCK SYRINGES

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In every doctor's office there is the occasion when a syringe becomes stuck. Many methods and devices are in use to separate the syringe parts, some of which are costly, both in equipment and breakage. Most of the surgical firms have a metal syringe which fits the end of the syringe which has become stuck, and warm water may be forced into the stuck syringe. However, if the least pressure out of a straight line is put on this equipment the end of the syringe is usually broken. To overcome this breakage, and because of the original cost of the syringe provided by the surgical firms, I was of the opinion something very simple should be used, and I had this made for a few cents. It is as follows. An ordinary 20 gauge needle to fit our syringes was soldered into an old trocar tube, the end of which had threads which fit on an Imperial dental syringe. The equipment is about three inches long, is flexible, and the total cost was only a few cents. Any ordinary syringe may be used, the smaller the barrel the better, and two needles soldered together. This little invention is made necessary because surgical houses have overlooked the demand for a "like to like" adapter, *i.e.*, Luer to Luer, etc.